Dear Patient,

Thank you for contacting us regarding our services at Raffi Hovsepian, M.D. Aesthetic Plastic Surgery and for scheduling an appointment with us. You can feel confident that our staff is committed to meeting your needs. Dr. Hovsepian is looking forward to meeting you. Please be assured that Dr. Hovsepian and his staff will work with you to prepare the best plan for you while taking the time to address all of your specific needs.

At Raffi Hovsepian, M.D. Aesthetic Plastic Surgery, we strive to provide the most current, safe and effective procedures available today. By combining procedures that have stood the test of time with newly proven advances in technology, our office is on the cutting edge and able to provide you with the best options available.

In order to minimize your wait time, **please complete the enclosed New Patient forms prior to your visit and bring them with you to your appointment.** In the meantime, if you have any questions at all, please feel free to call our office. The entire office is dedicated to giving you the best experience available.

If for any reason you are unable to keep your appointment, please contact us within 24 hours of your scheduled appointment to cancel or reschedule. Appointments that are not cancelled 24 hours prior to your consult will be charged the basic consult fee of **$200.00** on your credit card. We understand that some delays are unavoidable but please be aware that if you are 30 minutes late (or later), we will do our best to fit you in but you may have to wait or reschedule.

Thank you for choosing Raffi Hovsepian, M.D. Aesthetic Plastic Surgery!

Sincerely,

Raffi Hovsepian, M.D. and Staff

CONTACT US

www.RHMD.com PHONE 310.999.1003 FAX 866.694.4487

BEVERLY HILLS OFFICE

416 North Bedford Drive
Suite 200
Beverly Hills, CA 90210

INTERNATIONAL OFFICES

For international patients residing in Europe, the Mediterranean and the Middle East, office consultations can be schedule at Dr. Hovsepian's satellite office in Athens, Greece. Additionally, for patients residing in South America, office consultations can be scheduled at Dr. Hovsepian's satellite office in Rio de Janeiro, Brazil.

EUROPE

41 Karneadou
Kolonaki
Athens 10676, Greece

SOUTH AMERICA

351 Rua Visconde de Piraja
Ipanema
Rio de Janeiro 22410, Brazil

Date: ___/____/____

Name: [First] _____ [M.I.] _____ [Last] _____ ☐ Male | ☐ Female

Address: _____ [Apt.] _____ Age: _____ D.O.B: ___/____/____

City: _____ State: _____ Zip: _____ Home Tel: _____

Social Security #: _____ Drivers License #: _____ Work Tel: _____

Marital Status: ☐ Single | ☐ Married | ☐ Other E-mail: _____ Mobile Tel: _____

SPOUSE CONTACT

[If applicable]

Name: [First] _____ [Last] _____ Spouse's Mobile Tel: _____

Spouse's Employer: _____ Spouse's Work Tel: _____

EMPLOYMENT INFORMATION

☐ Full Time | ☐ Part Time | ☐ Student | ☐ Retired | ☐ Other Occupation: _____

Employer/School: _____ Work Tel: _____

Work/School Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

[not in your household]

Name: [First] _____ [Last] _____ Home Tel: _____

Relationship to Patient: _____ Work Tel: _____

Address: _____ City: _____ Mobile Tel: _____

State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Telephone: _____

Name of Insured: [First] _____ [Last] _____

Policy #: _____ Group #: _____ Co-pay? ☐ Yes | ☐ No If Yes, Amount: $_____

Secondary Insurance Company Name: _____ Telephone: _____

Name of Insured: [First] _____ [Last] _____

Policy #: _____ Group #: _____ Co-pay? ☐ Yes | ☐ No If Yes, Amount: $_____

I understand that office visit charges are payable on the day service is rendered. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Raffi Hovsepian and myself.

Signature: (Patient, Parent or Guardian)_____ **Date:** _____

REFERRAL INFORMATION

Referring Physician or Patient: _____

How did you hear about Dr. Hovsepian? _____

Have you been to our website [www.RHMD.com]? ☐ Yes | ☐ No If yes, was our website helpful? ☐ Yes | ☐ No

If No, please list reason: _____

PROCEDURE INFORMATION

What is the reason for your visit today? *[Check all applicable procedures below]*

FACE	BREAST	BODY	SKIN
☐ Facelift	☐ Breast Augmentation	☐ Liposuction	☐ Botox Cosmetic
☐ Cheek Lift	☐ Breast Lift (Mastopexy)	☐ Tummy Tuck	☐ Facial Fillers
☐ Brow Lift	☐ Breast Revision / Repair	☐ Mommy Makeover	☐ Juvederm
☐ Neck Lift	☐ Breast Implant Exchange	☐ Body Lift	☐ Restylane /Perlane
☐ Liquid Facelift	☐ Breast Capsulectomy	☐ Buttock Augmentation	☐ Prevelle
☐ Facial Fat Transfer	☐ Breast Reduction	☐ Arm Lift (Brachioplasty)	☐ Radiesse
☐ Facial Implants	☐ Breast Asymmetry	☐ Thigh Lift	☐ Fat Injections
☐ Lip Augmentation	☐ Male Breast Surgery	☐ Fat Transfer	☐ Skin Resurfacing
☐ Chin Augmentation			☐ Skin Tightening Laser
☐ Ear Reshaping	Other: _____	Other: _____	☐ Hand Rejuvenation
☐ Upper Eyelids	_____	_____	☐ Hyperhidrosis
☐ Lower Eyelids			☐ Skin Care
☐ Rhinoplasty			Other: _____
Other: _____			_____

Please describe why you are interested in having the procedure(s) listed above: _____

_____

Have you consulted with other physicians about procedure(s) indicated above? ☐ Yes | ☐ No

If No, please list reason: _____

Is this procedure a revision from a previous surgery? ☐ Yes | ☐ No

If Yes, how many previous surgeries? _____

SURGERY SCHEDULING QUESTIONAIRE

To help us understand your particular needs and time preferences for your surgery, please provide us with the following information:

What is you time preference for your Procedure? Within the next: ☐ Month | ☐ 3 Months | ☐ 6 Months | ☐ 1 Year

Does your home or work schedule permit such flexibility whereby you could have your aesthetic surgery done on "short notice", i.e. 10-14 days advance notice for a discount on your fees? ☐ Yes | ☐ No

HEALTH INFORMATION

PATIENT INFORMATION

Name: [First] _____ [M.I.] _____ [Last] _____ D.O.B___/____/____

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Primary Care Physician: _____ Internist: _____ Cardiologist: _____

Age: _____ Weight: _____ Height: _____ B/P: *[Avg. Resting B/P]* _____

Personal Past History

Do you have any chronic medical problems? *[Fill in box for those that apply]*

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS
☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Heart Failure	☐ Psychiatric Diagnosis	☐ Hepatitis
☐ Seizures	☐ Bleeding Problems	☐ Emphysema
☐ Heart Attack	☐ Liver Disease	☐ Stomach Problems
☐ Chest Pain	☐ Gastric Reflux	☐
☐ Asthma	☐ Cancer	☐ Other: _____

Is there a personal or family of anesthetic complications or malignant hyperthermia? ☐ Yes | ☐ No

If yes, please explain? _____

Family History

Do you have a family history of any medical problems? *[Fill in box for those that apply]*
Please indicate Family member(s): _____

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS
☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Heart Failure	☐ Psychiatric Diagnosis	☐ Hepatitis
☐ Seizures	☐ Bleeding Problems	☐ Emphysema
☐ Heart Attack	☐ Liver Disease	☐ Stomach Problems
☐ Chest Pain	☐ Gastric Reflux	☐ Breast Cancer
☐ Asthma	☐ Cancer	☐ Other: _____

Please list all prior Operations:	**Date**	**List any complications:**
1. _____	____/____/____	_____
2. _____	____/____/____	_____
3. _____	____/____/____	_____

Please list all prior Hospitalizations:	**Date**	**List any complications:**
1. _____	____/____/____	_____
2. _____	____/____/____	_____
3. _____	____/____/____	_____

Please list ALL medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.) _____
_____

Social history

Do you use Aspirin or medications containing Aspirin? ☐ Yes | ☐ No

Do you use Blood Thinners? (i.e. Coumadin, Heparin, Aspirin or Ibuprofen) ☐ Yes | ☐ No

If Yes, medication name: _____

Have you used Diet Pills in the last two (2) weeks? ☐ Yes | ☐ No

If Yes, medication name: _____

Have you taken Steroids within the last year? ☐ Yes | ☐ No

If Yes, medication name: _____

Have you ever smoked tobacco products? ☐ Yes | ☐ No

If Yes, # of packs per day: _____ # of years: _____

If you quit, when? _____

Do you use Recreational Drugs? ☐ Yes | ☐ No

If Yes, list type: _____

Do you Exercise? ☐ Yes | ☐ No

If Yes, how often: _____ How long: _____

Type of Exercise? _____

Is your Level of Activity related to health limitations? ☐ Yes | ☐ No

If Yes, please explain: _____

Do you have caps, bridges, dentures, or loose teeth? ☐ Yes | ☐ No

If Yes, please explain: _____

Review of Systems:

Please answer the following ***Yes or No questions to the best of your ability***. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	☐ Yes | ☐ No
Heart Attack	☐ Yes | ☐ No
Angina/chest pain	☐ Yes | ☐ No
Heart bypass surgery	☐ Yes | ☐ No
Pacemaker	☐ Yes | ☐ No
Heart Failure	☐ Yes | ☐ No
Irregular Heartbeat	☐ Yes | ☐ No
Heart Murmur	☐ Yes | ☐ No

Comments:_____

RESPIRATORY

Abnormal Chest X-ray	☐ Yes | ☐ No
Asthma	☐ Yes | ☐ No
Bronchitis	☐ Yes | ☐ No
Emphysema	☐ Yes | ☐ No
Recent Chest Infection	☐ Yes | ☐ No
Shortness of Breath	☐ Yes | ☐ No
Shortness of Breath at night	☐ Yes | ☐ No
Shortness of Breath on exertion	☐ Yes | ☐ No
Cough	☐ Yes | ☐ No
Cough with Sputum	☐ Yes | ☐ No
Sleep Apnea	☐ Yes | ☐ No
Use a C-PAP Machine	☐ Yes | ☐ No

GASTROINTESTINAL

Jaundice	☐ Yes | ☐ No
Gallstone	☐ Yes | ☐ No
Liver Disease (Cirrhosis)	☐ Yes | ☐ No
Hepatitis	☐ Yes | ☐ No
Ulcers	☐ Yes | ☐ No
Hiatal Hernia	☐ Yes | ☐ No
Heartburn	☐ Yes | ☐ No

SKIN

Cancer	☐ Yes | ☐ No
Radiation	☐ Yes | ☐ No
Atypical Skin Lesions	☐ Yes | ☐ No

ENDOCRINE

Diabetes	☐ Yes | ☐ No
Hyperthyroidism	☐ Yes | ☐ No
Hypothyroidism	☐ Yes | ☐ No
Hypoglycemia	☐ Yes | ☐ No
High Cholesterol	☐ Yes | ☐ No

PSYCHIATRIC

Depression	☐ Yes | ☐ No
Anxiety	☐ Yes | ☐ No
Psychiatric Care	☐ Yes | ☐ No
Obsessive Compulsive Disorder	☐ Yes | ☐ No

NEUROLOGICAL

Stroke	☐ Yes | ☐ No
Seizures	☐ Yes | ☐ No
Fainting	☐ Yes | ☐ No
Dizziness	☐ Yes | ☐ No
Headache	☐ Yes | ☐ No
Sciatica	☐ Yes | ☐ No
Herniated disc	☐ Yes | ☐ No
Arthritis	☐ Yes | ☐ No
Rheumatoid	☐ Yes | ☐ No

HEMATOLOGIC/ONCOLOGIC

Bleeding Tendency	☐ Yes | ☐ No
Easy Bruising	☐ Yes | ☐ No
Anemia	☐ Yes | ☐ No
Sickle Cell Disease	☐ Yes | ☐ No
Blood clots in legs	☐ Yes | ☐ No
Blood clots in lungs	☐ Yes | ☐ No
Radiation Therapy	☐ Yes | ☐ No

EYES

Cataracts	☐ Yes | ☐ No
Glaucoma	☐ Yes | ☐ No
Dry Eyes	☐ Yes | ☐ No
Do you wear Contact Lenses?	☐ Yes | ☐ No

Please list any other medical conditions that are **not** listed above: _____

_____

Have you had blood drawn in the past 3 months?	☐ Yes | ☐ No	If Yes, Location: _____
Have you had an EKG done in the last year?	☐ Yes | ☐ No	If Yes, Location: _____
Have you had a chest x-ray done in the last year?	☐ Yes | ☐ No	If Yes, Location: _____
Have you had a recent medical evaluation by your Internist, Cardiologist or Family Practitioner?	☐ Yes | ☐ No	If Yes, Doctor's Name: _____ Doctor's Phone Number: _____

FEMALE QUESTIONARE

Female Gynecological History:

Have you had had any previous pregnancies?	☐ Yes | ☐ No	☐ Natural Delivery ☐ C-Section Delivery
Total pregnancies: _____		
Date of pregnancies: ____/____/____ , ____/____/____		
Average weight gain during pregnancy: _____		
Did you breast feed during pregnancy?	☐ Yes | ☐ No	
Do you plan on having any or any more children?	☐ Yes | ☐ No	

Female Breast History:

Have you had a previous "breast" mass, suspicious biopsy, or cancer?	☐ Yes | ☐ No
Do you have a family history of breast cancer?	☐ Yes | ☐ No
Have you had a mammogram in the last year?	☐ Yes | ☐ No

If Yes, date of exam: ____/____/____

☐ Normal Mammogram ☐ Abnormal Mammogram

Current bra size? _____

Thank you for providing this important information!

Signature:

_____ _____ _____/_____/_____

[Patient/Parent/Conservator/Guardian] ***[If completed by other than Patient, indicate relationship]*** ***Date***

Comments:

_____

_____

_____

Reviewed by: _____ Date: _____/_____/_____

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Surgery Center and fees for the Anesthesiologist, as well as any special equipment fees or Assistant fees. Please note that Dr. Raffi Hovsepian's portion of the quote is good for 90 days only. If you choose to schedule the procedure more than 90 days in the future, it is possible that the fee will be different than the original quote. The Surgery Centers control their own fee schedules, and may increase their fees at any time. Payment for surgery may be made by cash, major credit card, cahiers check, or personal check. We also offer patient financing through Care Credit. Payment of non-surgical treatments such as Botox® Cosmetic and fillers are made at the time of service by cash or credit card; we are unable to accept personal checks for these treatments. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you the patient will be responsible for additional fees including but not limited to Operating Room or Anesthesia.

In regards to procedures that may or may not be covered by medical insurance, there may be situations in which part of your surgery would be considered functional or medically necessary. In that case, your insurance may pay part of the surgery fee. Dr. Raffi Hovsepian is not affiliated or listed as a provider on any insurance company. If the surgery center is a Preferred Provider and accepts your procedure under insurance, you will be responsible for your deductible and co-payments for the operating room & anesthesia, as well as payments for the cosmetic portion of your procedure. **Purely cosmetic services will not be billed to any third party insurer.**

Dr. Hovsepian is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. The failure to follow pre-surgical instructions includes: nicotine, alcohol, or drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen days prior to surgery or as the result of patient non-compliance, will incur a surgeon's rescheduling fee; this does not include fees that may be charged by the surgical facility. All fees must be paid prior to confirming any new surgical date.

Should you pay for your procedure with a credit card and then for any reason receive a credit, this credit will reflect a usage fee of 5% of the initial amount charged, due to usage fees that have been assessed to our account by the credit card company to process the initial transaction. Our office requires a non-refundable $2,000.00 scheduling fee to guarantee your surgery date & time. Surgery fees are due in full 21 days before your surgery date. There will be a $2,000.00 fee if you cancel or reschedule your procedure up to 14 days of your procedure. This fee increases to 50% of your surgery fee if you cancel between 8 and 14 days of your procedure. If you cancel within one week (7 days) of your procedure, you will forfeit 50% of your surgery fee. These penalties do not apply to illness related cancellations where a Doctor's note is provided. If a check is returned from the bank, the patient will be responsible for the amount of the check plus a $50.00 processing fee.

We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures. We have found that most patients are pleased to have all details known prior to scheduling.

Statement of Financial Responsibility

"I, the undersigned, have read the above & understand that I am responsible for all medical & surgical charges incurred by myself or my dependants. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. Hovsepian. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. Hovsepian. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature: (Patient, Parent or Guardian)_____ **Date:** _____/_____/_____

PHOTOGRAPHIC AUTHORIZATION

I consent to the taking of photographs or videotapes of myself or parts of my body by Dr. Raffi Hovsepian, or his designee, in connection with any and/or all plastic surgery procedure(s) to be performed by Dr. Raffi Hovsepian.

I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of any requested images for this purpose.

I understand that such photographs, videotapes or case histories may be published by Dr. Raffi Hovsepian and/or any party acting under his license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, internet web sites, publications, news media reports, newspapers, magazine, television or radio, billboard or any type of advertising for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Raffi Hovsepian.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. Raffi Hovsepian and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Signature: (Patient)_____ Date: _____/_____/_____

Section for Minors (Age 18 and under)

I have read the above Authorization and Release. I am the ***parent, guardian or conservator*** of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____ ____/____/____

(Parent, Guardian or Conservator Signature) Date

Dear Patient,

Welcome to Raffi Hovsepian, M.D. Aesthetic Plastic Surgery. We hope to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

I Will Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

I Will Contact the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will contact the office for my test results.

I Will Inform My Doctor if I Decide *Not* to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

Signature: (Patient, Parent or Guardian)_____ Date: _____/_____/_____

At the practice of Raffi Hovsepian, M.D. Aesthetic Plastic Surgery, your privacy is a very important part of our mission and plays a very big factor in your experience. Dr. Hovsepian and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.

As of April 14th 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations.
- How you may request copies of your healthcare information.
- How you may verify the accuracy of this information.
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, email, mail, or phone.

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a Notice of Privacy Practices by the office of Raffi Hovsepian, M.D. Aesthetic Plastic Surgery and I fully understand and accept the terms of this consent."

Signature: (Patient, Parent or Guardian)_____ Date: _____/_____/_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the practices of Raffi Hovsepian, M.D. and the practices that will be followed by all of Dr. Hovsepian's workforce members who handle your medical information.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

Dr. Hovsepian and his staff understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care, which are received or created by Dr. Hovsepian and his staff.

Your other medical treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your medical information.

This Notice will tell you about the ways in which Dr. Hovsepian may use and disclose medical information about you. Your medical information, also referred to as "protected health information," is that information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health information and related health care services.

In this Notice, we also describe your rights and certain obligations Dr. Hovsepian has regarding the use and disclosure of your protected health information. We are required by law to:

- Make sure that medical and other information that identifies you (protected health information) is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to protected health information about you.
- Follow the terms of the Notice that is currently in effect.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By becoming a patient of Dr. Raffi Hovsepian, you are giving consent for Dr. Hovsepian to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO."

We may use and disclose protected health information about you so that Dr. Hovsepian and his medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present condition or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care. We may also use and disclose protected health information about you so that we may be compensated for the medical treatment we provide you.

For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you. We may also use and disclose protected health information about you for Dr. Hovsepian's health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care. For example, we may use your protected health information to evaluate how we can better meet your needs or we may provide protected health information about you to an auditor who reviews our books so that we can keep our license to provide medical services in CA.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following uses of your protected health information may be made without any additional authorization from you. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by Dr. Hovsepian are only those, which are permitted under the law).

USES AND DISCLOSURES FOR APPOINTMENT REMINDERS

We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office. We will accommodate all reasonable requests.

USES AND DISCLOSURES TO OTHERS INVOLVED IN YOUR HEALTH CARE

We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

USES AND DISCLOSURES IN EMERGENCY SITUATIONS

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this notice as soon as reasonably practicable after the delivery of treatment.

USES AND DISCLOSURES FOR HEALTH-RELATED BENEFITS OR SERVICES

Dr. Hovsepian may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

USES AND DISCLOSURES REQUIRED BY LAW

We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

USES AND DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorities may include disclosure to a foreign authority that is working with the public health authority.

USES AND DISCLOSURES RELATED TO COMMUNICABLE DISEASES

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES

We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

DISCLOSURES OF ABUSE OR NEGLECT

We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with CA law.